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No. 85-1303

In The
Supreme Court of the United States
October Term, 1985

IN RE GUARDIANSHIP OF
SHARON KOWALSKI, WARD

On Petition for Writ of Certiorari
to the Minnesota Supreme Court

RESPONSE TO PETITION FOR WRIT OF CERTIORARI

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ARGUMENT

A. STATEMENT OF THE CASE

Sharon Kowalski, then age 27 years, was severely and permanently injured on November 13, 1983, in an automobile accident when struck by a negligent driver. As a result of the accident Sharon Kowalski is paralyzed and has severe brain injuries and is totally incapacitated, both physically and mentally. (App. 1-7).

Since her injury extensive litigation has taken place surrounding the terms of her guardianship.

On April 25, 1984, the District Court, Probate Division (the Honorable Bruce Douglas) found Sharon to be an incapacitated person and appointed Donald Kowalski. Sharon's father, to be Sharon's guardian. Karen Thompson, who claims to be Sharon's lesbian lover, fought for and was given equal access to visitation with Sharon Kowalski.

Subsequent to that order, Ms. Thompson began a media blitz and disregarded Sharon's well being for her own personal gain. She wrote letters to Sharon's parents claiming a gay relationship. (T339).* She fought to keep Sharon in a nursing home with an 87 year old roommate who chanted 24 hours a day in temperatures that soared to 94 degrees without air conditioning. She made numerous motions to prevent Sharon from receiving optimal care. She consistently and intentionally bombarded Sharon with negative messages about her parents, about being in a dangerous place, about getting good care, about her parents keeping her prisoner and various messages of that

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* Transcript from Trial Court will be referred to as T —.

sort. (T178). Because of these activities a new trial was held on May 3, 1985 and May 9, 1985.

On July 22, 1985 a new order was created giving Donald Kowalski all of the powers of a guardian and stripped Ms. Thompson of her powers. The order further contemplated complete denial of visitation by Ms. Thompson when it ordered Donald Kowalski to " . . . consider regarding visitation, the recommendation of medical and health care personnel and the needs and desires of the institution wherein the ward resides."

Following the July 22, 1985 order Donald Kowalski, as ordered by the court, followed the advice of four (4) separate medical doctors, all of whom had been Sharon's attending physicians, and terminated contact between Ms. Thompson and his daughter. (App. 8-19).

The Minnesota Civil Liberties Union then filed an appeal on behalf of Sharon Kowalski, claiming to be her representative. Thomas Hayes, the court-appointed representative, also filed an appeal, as did Ms. Thompson. Thomas Hayes also associated the MCLU with him without obtaining the permission of the trial court.

Donald Kowalski moved the Minnesota Court of Appeals to have the MCLU removed as attorneys for Sharon Kowalski and to deny their appeal as they had no standing to represent Sharon. The Minnesota Court of Appeals removed the appeal by the MCLU and also would not allow the MCLU to associate with the court-appointed attorney without order of the trial court. The Minnesota Court of Appeals did grant the MCLU amicus curiae status and allowed them to submit a brief, which they have done.

The MCLU then appealed that decision to the Minnesota Supreme Court and that appeal was dismissed. The MCLU then petitioned the Minnesota Supreme Court for a rehearing and that petition was denied.

The MCLU has throughout this action taken the side of both Karen Thompson and the court-appointed attorney, Thomas Hayes. They have nothing new to add.

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B. DISCUSSION

Sharon Kowalski Is Incapacitated And Lacks The Ability To Hire An Attorney Of Her Own Choice.

In his order of July 23, 1985, the Honorable Bruce Douglas made findings of fact regarding the mental status of Sharon Kowalski. He found in part that:

"2. The ward lacks sufficient understanding or capacity to make or communicate responsible decisions concerning her person.

4. The ward lacks sufficient understanding or capacity to make or communicate responsible decisions concerning her estate or financial decisions.

5. The ward has demonstrated behavioral deficits evidencing inability to manage her estate.

8. The ward is incapable of exercising the following rights and powers:

c. (2nd letter "c") to consent to necessary medical or other professional care, counselling, treatment or service.

12. The ward's ability to respond or communicate has been inconsistent and, at times, unreliable, which situation may or may not improve."

The findings of the trial court are clear that Sharon Kowalski is unable to hire an attorney. Even a response that she requests "help", the basis for the Minnesota Civil Liberties Union intervention in this matter, doesn't give a basis for the Minnesota Civil Liberties Union saying that they have been hired by Sharon. Any incapacitated person desires help, but she is incapable of understanding what type of help the Minnesota Civil Liberties Union can and will give. Dr. Cowan points this out in his August 27, 1985, affidavit (App. 20-24) in which he, Sharon's attending psychiatrist, states that:

> "14. It is my opinion based upon the history, the rehabilitation conference report dated October 9, 1984, conversations with her medical and nursing home personnel, perusal of medical and nursing home records, conferences with her attending physicians, and my own examination of Sharon Kowalski, that she would be unable to understand the questions and use the complex reasoning that would be required to give intelligent answers;
>
> 15. The whole, entire history shows that Sharon's brain damage causes her to be totally confused in answering questions. It is my opinion and belief that Sharon does not have sufficient understanding to make reasoned, intelligent answers to the questions as shown in these affidavits."

Important to note is that the MCLU solicited Sharon Kowalski. They went directly to her attempting to get hired. They went directly to a brain-injured individual who they knew lacked the ability to make decisions, probably at the urging of Ms. Karen Thompson, whom they have sided with all along.

Sharon Kowalski already has a court-appointed attorney who has been actively involved and who brought an appeal. He is advocating exactly what the MCLU is advocating. He filed an appeal of the July 23, 1985 order and the MCLU was granted amicus curiae status for that appeal. Any appeal brought by the MCLU is superfluous and unnecessary and acts only to dissipate the assets of an estate which has already been in court numerous times and continues to be forced to fight requests such as this.

How can an incapacitated ward with mental abilities of a six or seven year old, who gives inconsistent answers, hire an attorney? The answer is simple; she cannot. She doesn't understand what is being asked of her. Karen Thompson has admitted on the stand that she has personally experienced inconsistencies. (T349). The record is replete with inconsistencies, including wrong answers to simple questions such as her age and where she was presently residing. The physicians all point to inconsistencies (App. 8-19) and the court found such inconsistencies in its July 22, 1985 order.

It is clear that the MCLU is not neutral in this matter as they claimed they would be. They smell an issue and seem only to care about the issue. Why do they constantly fight the guardian despite the presence of medical reports contrary to their position.

Counsel's argument that Minn. Stat. § 525.56, Subd. 3(5) gives Sharon the power to approve "contracts for necessity" must be seen in light of the common law history of this concept. Common law gave incapacitated persons the power to contract for necessities to protect people such as merchants and others who contract with persons

who don't know of an incapacity. *Kay v. Kay,* 53 Ariz. 336, 89 P.2d 496, 120 N.E.2d 7; *Granes v. Norris,* 3 Ill.2d 112, 120 N.E.2d 7; *Talbert v. Ellzey,* 203 Miss. 612, 35 So.2d 628. This is not such a case. This matter is a case where the ward must be protected from the MCLU who comes directly to her, knowing of her incapacity, and gets her to respond on her machine that she wants help. This is clearly not what the statute anticipated. The court appointed the firm of Smith, Pringle & Hayes because the court knew and saw that Sharon was incapable of approving any contract. The court dealt with attorneys when they found that Sharon was incapable of consenting to ". . . other professional care . . ."

The appellants' use of criminal law cases to support their view is erroneous. This case is in no way similar to those cases where the parties have the mental capacity to make a determination. Where a party is unable to make that determination, it should not be the MCLU's right to make a determination that they have been hired. To protect the ward, the decision must be left in the hands of the court, not any attorney who comes around looking for work or smelling an issue.

———o———

CONCLUSION

For these reasons, a Writ of Certiorari should be denied.

Respectfully submitted,

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Ward

App. 1

INITIAL EVALUATION 10-9-84

REHABILITATION CONFERENCE

MILLER-DWAN HOSPITAL AND MEDICAL CENTER
and
NAT G. POLINSKY MEMORIAL
REHABILITATION CENTER

Rehabilitation Conference
Form MH-41

KOWALSKI, Sharon

MR # 10-48-52

R 305-1

Dr. S. K. Goff

date: 10/9/84

INITIAL EVALUATION

This is a 28-year-old woman who was admitted to the Rehabilitation Unit on 9/14/84 for a rehabilitation evaluation. She was involved in a motor vehicle accident Nov. 13, 1983. She sustained a severe closed head injury. Her emergency care was at St. Cloud Hospital. According to the reports, a CT scan at that time demonstrated a right temporal contusion, multiple areas consist with scattered cerebral hemorrhages. She was breathing spontaneously and demonstrated fixed flexion posturing of right side. Also had other injuries, including a fractured femur which required open reduction, subsequent fever spikes and wound infection problems following this. Subsequently seizure activity was demonstrated by EEG and she was placed on Dilantin therapy. She was hospitalized at St. Cloud from Nov. until July of 1984, then was transferred to the Country Manor Nursing Home in Sartell, Mn fol-

lowing this. According to the accompanied medical notes, her progress was extremely slow. Because of the severity of her injury and her slow progress, it was felt by her attending physicians that she would not benefit from an intensive rehab course at that time. She did have a rehab review by Dr. Keith Sperling sometime during her stay, a physiatrist from the University of MN. His report was not available. He did suggest that she be placed on Didronel to prevent heterotopic ossification. She did receive daily physical therapy at the Country Manor Nursing Home and occupational therapy, apparently some intermittent speech therapy, though the frequencies of these are unknown at this time. She was on medications at the time of her transfer, in the form of Dilantin 200 mg. b.i.d.; Symmetr 100 mg. b.i.d.; and was on tube feedings. She was allergic to Penicillin. Past medical history was unremarkable. Medical course during this stay has been unremarkable. She was seen in neurologic consultation and head to the right, both arms in flexion posturing, and spontaneous movements of the right hand were noted with marked proximal apasticity. Reflexes were hyperreflexic, bilateral plants extensor responses were noted in the lower extremities. Her yes/no responses seemed unreliable. Right Abducens palsy was demonstrated and some vertical nystagmus with antisocoric pupils. Markedly spasticity of her palate movements and increased gag reflex were noted. Dr. Holt suggested checking the CT scan to document the severity of posterior fossa injury, in addition to the cerebral injury, and rechecking an EEG. With the severity of the bulbar findings, a gastroscopy was recommended. If not done, a trial of Lioresal or Dantrium could be undertaken. CT scan did show some asymmetry be-

tween the size of the lateral ventricles, the right being more prominent than the left. Posterior fossa was unremarkable.

REVIEW OF HER REHAB PROBLEMS:

1) *Home situation*—The patient is single and was born in Grand Rapids. Grew up in the Nashwauk area. Has a 26-year-old sister in Hibbing; a 24-year-old brother in St. Peter. Both living maternal grandparents; 1 living paternal grandparent. Prior to her injury, the patient was living in St. Cloud. Her parents live in Nashwauk. Father is retired from Hanna Mining, but does do some self-employed work at this time in landscaping. Her mother is a homemaker. Patient did complete a high school education. She went to college in Bemidji, Hibbing Junior College, and graduated from St. Cloud as a physical education instructor. She had been layed off, however since the spring of 1983 and had reportedly been discouraged prior to her accident about lack of employment. She is generally interested in physical activity, sports of all kinds, outdoor activities. Prior to her accident, she lived in the home of Karen Thompson in St. Cloud. At this time, ultimate home disposition planning has not been decided. Currently the matter regarding disposition and guardianship is in the hands of the District Court in St. Cloud. Guardianship is currently being held by the father. As we understand, the matter is going to be settled in the Court in mid October. Disposition planning, thus, will have to wait until this decision is made. If parents are granted guardianship, parents would prefer Sharon to remain within reasonable commuting distance of their home, and ultimately if home care is possible, they would like to pursue this possibility.

If she goes back to St. Cloud, she would most likely be back initially to the St. Cloud Nursing Home. If Karen Thompson is granted guardianship, she would eventually like to care for Sharon in her home. Currently the patient's medical care is being supported by Minnesota Medical Assistance. Her application for Social Security has been made and litigation is also pending. Also investigation into a supplemental insurance policy.

2) *Communication and cognitive dysfunction*—The patient was evaluated in detail by both the psychologist and the speech therapist. The following is a summary of their findings. Because of the limited cognitive capabilities of this patient, the testing was informal. In many tests only portions of the tests could be applied. Portions of the Minnesota test for the different diagnosis of aphasia; the Wigg-Semel test of linguistic concepts, the Peabody Picture Vocabulary test; the Peabody Individual Achievement test were administered. Auditory comprehension felt to be severely impaired, meaning that her responses were inconsistent and spotty. She had limited expressive abilities which also limited evaluation of auditory comprehension. The patient was tested with yes/no responses by head nods, scanning, position to pointing using the fingers of the right hand, positioned statements using finger movements, following directions and scanned by the examiner. In scanning the examiner goes over a series of response choices, responding by pointing to each item hoping to elicit a response from the patient. The examiner felt that responses to all modes of communication were inconsistent. The results tended to be different with the same question getting different responses. It was noted that there was no consistency between which modes

seemed to work the best. Variation was not related to temporal relationship or the patient's condition. Therapist felt that the scanning modalities and the position pointing responses were most successful. The most ineffective and unreliable response mode was the finger response to a conditioned question or statement. Patient's ability to follow direction was tested in detail. She was presented with body commands, as "raise your hand". With repeat efforts, she responded accurately to only one command out of seven. When the commands, however were repeated and gestures were added, she could respond in an improved manner, and in this case respond to three more of the commands (out of seven). Plus it was felt that she inconsistently comprehended commands. It was apparent that gesturing enhanced understanding. The therapist felt that repetition of a command did not necessarily increase the ability to comprehend. Her ability to understand words, sentence and paragraphs was also tested. Comprehension of common words using the scanning response system was 100% accurate. This was the only consistent performance noted by the therapist during her entire examination. Pointing responses were generally ineffective. She was definitely correct only 50% of the time. Part of this limitation may have been her spasticity and postural limitations. The Peabody Picture Vocabulary test where the patient selected one of four pictures responding to a presented word with the scanning response mode produced variable responses. Initially responded to 13 of 14 items. Then was inconsistent in her responses following that. The Minnesota test, looking at sentence level understanding, demonstrated variability, using all modes of responsiveness. She responded to 12 of 15 general yes/

no questions with head nods. This was not the standard and usually she did not do this well. Part of this was due to the difficulty detecting definitive head nod. The therapist felt therefore that this was an ineffective measure of comprehension. Using the scanning system she was felt to be at essentially a chance level in her responses. Given a descriptive statement regarding a single picture, she was 80% accurate in responding by moving the corresponding finger. On the Minnesota test, she was unable to accurately answer yes/no questions of paragraph length material. No response was felt to be effective. Therefore, the conclusion was that she could comprehend inconsistently at a common word level and sentence level; unable to comprehend paragraph length material. Her ability to comprehend conditional statements was also tested. These consisted of rather concrete personal questions, such as, "If your hair is red, move your finger", and higher levels of information, such as, "If lunch comes before breakfast, move your finger". It is felt by the examiner that these conditional statements were beyond the patient's ability as to understand, and this included both the concrete personal areas and higher level areas. The Reading ability was also tested and indicated a severe impairment. The Minnesota test showed the recognition of words was 87% accurate with position pointing system, 75% accurate with a scanning system. The level of comprehension was also assessed. Responses to general yes/no questions were variable. Head nod responses were at the chance level. In the Peabody Individual Achievement test, no basal score could be obtained. This required the patient to read a sentence and select one possible picture of four which corresponded to the sentence. The examiner felt in sum-

mary that the patient was able to inconsistently read and comprehend at the single word level. Expressive communication was evaluated and felt to be severely to profoundly impaired. During the evaluation sessions, speech was observed. Spontaneous verbalizations were noted and that did not appear to be purposeful or reactive. No voicing to command was noted. She was observed on a videotape to be imitating vowels. It was noted that she may have done a bit of humming during her physical therapy sessions. The therapist felt also that yes/no responses observed through head nods as a response mode were not reliable. Pointing responses were functionally poor for physical reasons with her accuracy often depending on where the response was located on the page before her. Many of her responses were noted to be left to the interpretation or assumptions by the observer. It was felt that the one finger—yes, two fingers—no, modality was not functional or was felt that scanning is a system that the patient could use, although the consistency of her responses was adversely affected by her decreased comprehension. A number of non-vocal systems were tried using alphabet boards, mechanic communicator and others. Physical limitations complicated use of these devices. For example, she was able to find the "S" on the alphabet board to spell her name, but could not find the second letter. Her writing skills demonstate a severe to profound impairment. She could write her first and last name with partial and variable legibility. Could not write letters to dictation legibly, and all attempts to write common words to dictation were not legible. Did not respond when asked to write numbers. Oral motor function was evaluated. Trace movement of her lips were noted. Chewing-type

movements were spontaneously noted of the jaw. The tongue could be brought to the lips. Spontaneous voicing was occasionally heard, but not on command during sessions. She had a hyperactive gag reflex and could not swallow on command. Because of these difficulties, a barium swallow was subsequently recommended. The overall summary of the speech function is that she does demonstrate scattered emerging abilities in all areas tested. The patient was also seen by the psychologist for recognitive evaluation over a period of several days to try to evaluate consistency. She was administered several formal psychometric tests and a variety of informal test materials. As to her difficulty in responding consistently, she was unable to complete any of this formal testing. Testing tried by the psychologist included the color form preference subtest, the recognitive diagnostic battery, a test of non-verbal intelligency, collected items from the Stanford-Binne-Intelligence Scale. On the color form preference subtest, in which patient shows preference for color indicates a level of responding, which is less mature developmentally than individual responding to form stimuli. Based on this subtest, her cognitive functioning ability would be below a 6 or 7 year age level. With tests of non-verbal intelligence and a language free test of non-verbal intelligence, she was only able to obtain three correct responses of six on the pratical ones. A full-scale test was not administered because of performance on the initial items. A full-scale test was not administered because of performance on the initial practice item. Multiple items from the Standford-Binne' were administered, including identifying objects, body parts and including a delayed response for items at year level two. She was able to identfy body parts

and was able to accurately locate some objects. Some of the responses were difficult to interpret for reasons indicated in the speech evaluation. She was able to correctly identify however, on the delayed response which box a small object was hidden under. Test results and observations indicate cognitive function to be severely impaired. Her attention processes were felt to be good. She could make appropriate eye contact with testing material. Performance on the delayed response test does suggest that her ability to concentrate without distraction is a relative strength. Memory abilities are difficult to assess with this degree of impairment. They do seem to be relatively intact for simple identification of objects. This would indicate that her memory storage of verbally acquired information is present for some items, but the extent of her memory is not known, but is likely to be greatly diminished compared to premorbid levels. Her information processing in general was inconsistent, though she demonstrated appropriate responding, slow responding and occasionally no responding to test material. This was made difficult again for reasons stated in the speech evaluation, but it also reflects a slow information processing speed. She did not demonstrate any behaviors which would indicate any initiative on her part. She did demonstrate simple reasoning skills and ability to respond to commands. She did show a tendency to perseverate, indicative of a low developmental level of cognition. Her learning ability is likely to best consist of a repetitive stimulation and shaping of her responses. Much of her expressive repertoire at this time seemed to reflect overlearned responses to some degree, as demonstrated by her ability to point her finger. The examiner felt that the test results and inter-

pretations reflect an estimate of her current cognitive skill, compounded by her limited output modalities. It is felt by the psychologist that at a functional level, she was in a severe range of impairment. He felt, however, that her actual cognitive function at times may be higher, which would be consistent to a head injury, when at times islands of increased function appear. It is likely that her judgment or ability to make decisions for herself would be severely impaired, significantly due to her difficulty establishing a reliable means of communication. It is very easy to lead her responses, misinterpretate her gestures. This supports the opinion of the psychologist that she is not able to make judgments and decisions on her own.

3) *Upper extremity paresis*--This shows motor spasticity and flexor tone bilaterally, particularly proximally with significant fluctuation of this tone. Her activement movement is restricted to distal function on the right from the elbow to the fingers. No significant subluxetion of the shoulder was noted. Passive range of motion is from 0-90 degrees for shoulder abduction, 0-110 degrees of flexion of the shoulder. The remainder of her movements in her upper extremities can be stretched to within normal limits on the left, except for a neutral position of her wrist. On the right, there is 65 degrees of shoulder abduction, 40 degrees of shoulder flexion, ¾ range of forearm supination. Motion is resisted more on the right. Relaxation does encourage increased range of motion and a greater range of motion can be obtained supine rather than sitting. No carry-over of relaxation was noted. Motor skill could not be effectively formally evaluated, however she did demonstrate full active elbow flexion/extension, wrist flexion, finger flexion/extension, and ¾ active wrist exten-

sion. Grip strength on the right was measured at 15 lbs. Lateral pinch 6.5 lbs., and 2-point pinch 2 lbs.; all below the 10th percentile for her age. In the left upper extremity, only slight positional movements of the 5th fingers were noted but were nonfunctional. Functional use could not be formally evaluated. She could do a gross grasp and release with items as small as a paper clip. She had difficulty placing any objects because of her proximal dysfunction. She was able to actively flex her elbow in a functional manner, such as lifting her arm off a table. She did demonstrate the ability to use a dowel to point to objects and was able to wipe her mouth, but it was inconsistent. She was occasionally spontaneously noted to scratch her head or rub her nose. She can hold a pen in a functional writing position once it is placed. All movements were noted to be very slow. Sensation could not be adequately evaluated in her upper extremities. There was no evidence at least of severe tactile impairment.

4) *Visual dysfunction*—She does wear glasses, but apparently does not have a current prescription due to the accident. She can visually track in all directions. Loses track of objects at about 45 degrees to the right and the left. Her head is in the midline. Good tracking upward is noted, but not downward. As previously noted, she does have a right Abducens palsy and nystagmus, resulting in disconjugate eye movements. Formal visual testing would not be possible with this level of cooperation.

5) *ADL's*—Patient is completely dependent in her ADL's at this point. She can comb the front of her hair and bring her toothbrush to her mouth, but is not functional enough to carry through with these activities. Sig-

nificant verbal cuing is needed. The bladder is handled by diapers. Attempts have been made to evaluate her ability to void on regular intervals, but this has not been successful as of yet.

6) *Swallowing*—See the speech evaluation above for evaluation of oral-motor function. In addition, she did have a barium swallow. When the bolus was placed in her oral cavity, it was noted that there was no attempt to make the opaque into a bolus in preparation to initiate the swallowing reflex. Swallowing did not follow. When the swallowing reflexes was initiated, the barium did move readily through the pharynx and the hypopharynx and showed nomal esophagus motility. On occasion, however, the barium would leave the oral cavity as she extended her neck, and it would rest in the valleculsae without initiation of the swallowing reflex. On occasion during the swallow, the patient did aspirate the barium into the larynx and proximal trachea. Conclusion of this swallow was that it confirmed marked neuromotor discoordination, inappropriate initiation of the swallowing reflex, poor bolus formation and demonstrated a significant threat of aspiration. These findings would go along with the history that the patient has occasionally swallowed.

7) *Lower extremity disfunction*—formal testing is not possible and range of motion varied according to relaxation techniques at the time. On the right, her hip flexion was 95 degrees, and extension lacked 5 degrees. Knee flexion and planter flexion were normal. Abduction was limited on the right to 25-30 degrees. It was noted that the patient could actively abduct her knees. On the left, she was generally tighter. Extension lacked 30-40 degrees, abduction was approximately 10-15 degrees, dorsiflexion

lacked 20-25 degrees. She does show active control of the right lower extremity against gravity with her hip flexion, knee flexion and hip extension and knee extension. Hip abduction and adduction were seen with gravity eliminated. Traces of movement were noted inconsistently in the left. Hypertonicity was not in both lower extremities, particularly on the left. Adductor tone was noted in all positions. This could be released with relaxation techniques. Minimal reciprocal movements were noted in the right lower extremity.

8) *Dysmobility*—Patient was unable to initiate rolling on the mat, but she can turn her head in the direction of the roll. No trunk rotation was seen with any activities. No active illegible extension was noted during the prone position. A lack of head control was noted when she was prone over the bolster. Increased arm tone was noted during that time. She had poor balance in the sitting position, sitting in a flexed posture. Much relaxation must be effected before her feet can be placed flat on the floor. Little trunk control and head control were noted during sitting. That which is seen when constant verbal commands are presented, thus she needs moderate to maximal assist of one to sit. At times, she is able to extend her right arm and grip the side of the mat, thus hold herself up for short periods of time. Transfers from wheelchair to mat require maximum assistance of two, with a pick up or a standing pivot transfer. She has not had enough active lower extremity activity or weight bearing abilities to make her a candidate for gait activities. The wheelchair posture with a highback chair was poor. She tended to sit with weight bearing on the left hip, the right hip retracted. The head was generally flexed and rotated. The

lower extremities tend to be strongly adducted and the right leg tends to be in the extended position.

9) *Spasticity*—Has been described in the extremity exams above. There is marked spasticity and variable tone in all 4 extremities. Tone is affected by timing, positioning. She has been on Symmetrel in the past. It is not known whether she had been on a trial of Lioresal or Dantrium. She has not had any surgical procedure for spasticity control.

10) *Behavior and adjustment*—During her therapy sessions, she has been somewhat variable, at times alert, and at times lethargic. Her attention span has been inconsistent, but as noted above, at times has been quite good. She has been noted at times to respond during the full ½-hour treatment session. Other times, there has been little response. There does not seem to be any pattern with this level of responsiveness, which is what one would expect secondary to the head injury. Her appearance is that of a tendency for her head to be held in a flexed, slumped posture, turning her head to command. No spontaneous communication behaviors were noted. There has been no belligerent behavior. It is difficult with her to ascribe her periods of "withdrawn behavior" to behavioral dysfunction, or simply to alterations of level of consciousness. During her periods of less alertness, she would automatically appear withdrawn. Therapists all felt that her level of cooperation or variable did not change significantly throughout her stay. The variability of her cooperation did not seem to be affected by who was present in the room.

11) *Assessment and recommendations*—Patient's overall level indicates a severe level of impairment, like

significant brainstem and cerebral dysfunction. She is now 11 months post-injury. Limited improvement, neurologically speaking, can be expected. The previous pattern of very slow improvement could well continue for an extended period of time. Although this is highly variable, most patients are described as improving cognitively for a period of one year after injury, whereas the motor improvements may well extend to 2 or 3 years. This does not preclude the possibility that some improvement may occur through behavioral means and training methods. It is felt that at this point the patient is incompetent to make decisions regarding her own welfare, and she is not able to make judgments or decisions on her own.

12) *Recommendations*—

1) At this time, feeding should be held. Aspiration has been demonstrated. There is a definite threat for silent aspiration of oral materials into her lung. For this reason, a feeding gastrostomy was performed. It was suggested that this be used and her feeding function could be re-evaluated at 3 month intervals. If the threat for aspiration decreased, her oral feeding could be accomplished at that time. It would be permissible for small amounts of fluids in her mouth, and such things as lemon-flavored oral swabs.

2) Spasticity is a significant problem at this point. Continued observations on the part of the therapists as to which positions facilitate relaxation should be continued and this reported to the nursing staff. If she has not had a trial of Lioresal, this would be recommended to see if it would functionally improve her posture, her ability to use her right arm, and her head control. At this point, we would not consider her a candidate for more definitive spasticity treatments, that is neu-

rosurgical or orthopedic procedures, because of her poor level of motor function and her decreased level of cognitive function.

3) She should have a special wheelchair. There are several avenues that may be explored, one would be purchase of a stock wheelchair with a variety of bolster attachments, foot boards, lap boards to accomplish good positioning. She would require a high-back system, good head support, shoulder support system, a knee separator to prevent excess abduction. She will require experimentation of hip and knee position to facilitate relaxation.

4) It is felt that because of her severe impairment and slow rate of recovery, and limitations of potential, prolonged in-patient rehabilitation in a hospital unit would not be indicated at this time. It is recommended, however, that she does continue in an on-going rehab program. Components of this program should include daily physical therapy, daily occupational therapy, and daily speech therapy for a period of time such that progress can be closely monitored and evaluated. Also a psychologists contribution to cognitive re-training and monitoring would be desirable. Specific recommendation of individual therapists could be obtained by perusing their reports. It was felt important by the therapists that this close follow-up be indicated, because of the difficulty of assessing the accuracy of this patient's responses. For this reason, any program using persons other than therapists would need to be monitored and directed because of the potential problem of presenting materials that were inappropriate or too advanced for this patient. At this point, the ultimate disposition of this patient is uncertain for reasons stated in the report. It is felt that eventually she could be cared for in a home situation. However, it was felt in her best interest

that this would not be appropriate at this time for the above stated reasons. If the patient were to remain in the Duluth area, the most appropriate program could be obtained at Park Point Manor Nursing Home. This facility has a skilled rehabilitation section, specifically used for the young physically handicapped adult. To my knowledge, there are only 3 of those units currently in the State of MN. The residence does offer the comprehensive approach recommended. Approximately ⅓ to ½ of their patients were head injured patients and would provide a milieu of similarly injured patients undergoing similar therapies and in a similar age group. This would give the opportunity for medical follow-up, which should occur as well. Were she to remain in this area, we would see her at approximately monthly intervals. If she were to remain in another area, this responsibility would then be assumed by a physician in that area.

S. K. GOFF, M.D.

SKG/slh
D&T: 10/9/84

218-727-7451

Cowan Psychiatric Associates, Ltd.

330 Medical Arts Building
Duluth, Minnesota 55802

October 15, 1984

Jack Fena
Attorney at Law
P.O. Box 667
Hibbing, Minnesota

Re: Sharon Kowalski

Dear Mr. Fena:

Please be advised that at your request I interviewed Sharon Kowalski at Miller Dwan Hospital on October 4, 1984. Prior to my examination, I reviewed the chart.

Sharon was lying quietly in bed, appearing to be completely helpess. When I came into her room, the nurse was putting on her night clothes.

I attempted to interview Sharon but she was unable to speak. I was informed that she could answer questions by blinking once for a yes answer and two for a no answer. I proceeded therefore to determine if she was well oriented etc but when she did respond her answers were inconsistent. At one time she would blink once and when the same question was repeated she would blink twice.

Apparently Ms. Kowalski will require a fairly prolonged period of nursing home care along with some intensive physiotherapy and possibly psychotherapy if her condition improves to the point where she is amenable to such therapy. However at this point and in the immediate future she will require a great deal of tender loving care and parental love which is unconditional.

Sincerely,

/s/ George M. Cowan, M.D.

GMC/me

400 East Third
Duluth, MN 55805

THE DULUTH CLINIC, LTD.

December 20, 1984

Mr. Jack Fena
Attorney at Law
PO Box 667
311 East Howard Street
Hibbing, Minnesota 55746

RE: SHARON KOWALSKI
DC# 63 38 98

Dear Mr. Fena:

I saw Miss Sharon Kowalski at Park Point Manor on December 13, 1984 and spent some time with her, trying to assess how easy it is to communicate with her, how well she comprehends and if she is able to make significant decisions. I spent at least half an hour with Sharon. We were in a quiet, well lit room without any interference. She was sitting in a chair. She was alert and she was cooperative to the best of her ability.

She is severely impaired physically due to her closed head injury in 1983 and has only very limited ability to move her right hand and the fingers of her right hand. She is unable to speak or swallow. She is unable to move her other extremities. She has been given a small electronic computer printer which prints out messages on a strip of paper when she presses the letters with a pencil. This requires only light touch. She was able to spell the word cat. I asked her to spell her name, Sharon, but she only wrote SA. Using this little printer may turn out to be

very helpful; however at the present it is a very time consuming task for her and I did not try to get further information in this manner.

I presented her with a series of nonstructured statements or questions to which she could answer "yes" or "no" by moving her index finger or her thumb. I shall list these statements and questions and her replies separately.

It appears to me that there was quite a bit of inconsistency in her answers. She is apparently not aware of the fact that she is at Park Point Manor in Duluth, but thinks that she is at the Country Manor Nursing Home in St. Cloud. She does not understand the word "parents", which apparently is too abstract for her. It appears that she likes her mother, her father and Karen Thompson and enjoys their company. She thinks of Karen Thompson as a good friend.

I do not believe that Sharon Kowalski is able to make any significant decisions as to her future care. She had extensive psychological evaluation in October at Miller Dwan Hospital. At that time, it was felt that she was functioning mentally at a level below six or seven years of age and it is my opinion that she continues to function at this level. It is also my opinion that it is appropriate for her father as her parent to retain guardianship of his daughter.

I would expect that any improvement in her physical or mental condition will only be slight.

I do not believe that it would be appropriate for Sharon Kowalski to appear in court at this time because it would be too stressful and confusing an experience for her. I

believe it would be all right for her to visit her family at Christmas since they are able to take care of her physical needs on a short time basis at this time.

Yours truly,

/s/ J. C. Moller, M.D.

JCM:rhe

Enclosure

INTERVIEW WITH SHARON KOWALSKI 12/13/84
J. C. MOLLER, M.D.

This is Duluth	No*
The sun is shining	Yes
It is raining	No
It is snowing	No
This is Grand Rapids	No
This is Nashwauk	Yes*
This is Duluth	No*
Your sitting in a chair	Yes
Is this Minneapolis?	No
The sun is shining	No*
Do you like ice cream?	Yes
Do you like hamburgers?	Yes
Do you like to watch TV?	Yes
The sun is shining	Yes
Do you want to live with your parents?	No

*ANSWER IS INCONSISTENT

Do you want to stay in a Nursing Home?	No
Do you want to live by yourself?	Yes*
Do you want to live with your father?	Yes
Do you want to live with your mother?	Yes

(the patient apparently does not understand the meaning of the word "parents".)

Do you like Karen?	Yes
Do you want to live with Karen?	Yes
Does Karen live in Duluth?	No
Does Karen live in Minneapolis?	No

*ANSWER IS INCONSISTENT

INTERVIEW WITH SHARON KOWALSKI 12/13/54
J. C. MOLLER, M.D.

Does Karen live in Grand Rapid?	No
Did you know Karen when you were a little girl?	No
Have you known Karen for five years?	Yes
Have you known Karen for one year?	Yes
Have you known Karen for more than one year?	Yes
Did you teach Physical Education?	Yes
Do you think Christmas is coming soon?	Yes

Do you want to go home?	Yes
Would you like to live with your parents?	No*
Would you like to live with Karen?	Yes
Has Karen been good to you?	Yes
Do you like it here?	Yes
Do you like to read?	Yes
Can you swim?	No
Is this a nursing home?	No*
Is thus Duluth?	No*
Is this Chicago?	No
Is this Nashwauk?	No
Is this Grand Rapids?	No
Is this Superior?	No
Have you been at Miller Dwan Hospital?	No*
Have you been to Duluth?	Yes
Are we in Duluth?	No*

*ANSWER IS INCONSISTENT

INTERVIEW WITH SHARON KOWALSKI 12/13/54
J. C. MOLLER, M.D.

Are we in Grand Rapids?	No
Are we at Country Manor?	Yes*
Are we at Park Point Manor?	No*
Is it winter?	No*
Is it dark?	No

*ANSWER IS INCONSISTENT

Is it snowing?	No
Is this St. Cloud?	Yes*
Does your father live in St. Cloud?	No
Does your father live in Nashwauk?	Yes
Would you like to live with your father?	Yes
Would you like to live with your mother?	Yes
Would you like to live with Karen?	Yes
Do you want to live here?	Yes
Would you like to live in Minneapolis?	No
You are in Duluth, do you believe that?	No*
Would you like to go back to bed?	Yes
Do you hurt anyplace?	Yes
Does your head hurt?	Yes
Do you hurt anywhere else?	Yes
Do you hurt everywhere?	Yes
Does your toe hurt?	Yes
Does your hair hurt?	Yes

*ANSWER IS INCONSISTENT

THE DULUTH CLINIC, LTD.

400 East Third Street
Duluth, MN 55805

Mr. Jack Fena
Attorney at Law
PO Box 667
Hibbing, MN 55746

May 7th, 1985

Dear Mr. Fena,

I see Sharon Kowalski briefly once a month at Park Point Manor Nursing Home. On my visit May 6th, 1985 she was noncommunicative and appeared depressed. I conferred with the nurses who take care of her; they tell me that after Miss Karen Thompson's visits with the patient she seems more depressed and curls up in a fetal position. The nurses consider Miss Thompson's visits as abusive to a vulnerable adult.

In our local newspaper I have read that Miss Kowalski types sentence long messages to Miss Thompson on her small communicating machine; I seriously question her ability to do so spontaneously. I saw Miss Kowalski use this tool in December, 1984, and it was cumbersome for her to type out short single words; at that time she was unable to type out her own name.

In my opinion, Miss Kowalski remains unable to make any significant decisions and she is a highly vulnerable adult. In my opinion the the visits of Miss Karen Thompson are disruptive and harmful and therefore not in the best interest of the patient.

Yours Truly,

J. C. Moller, M.D.

THE DULUTH CLINIC, LTD.

400 East Third Street
Duluth, MN 55805
218/722-8364

May 8, 1985

TO WHOM IT MAY CONCERN

RE: SHARON KOWALSKI

DULUTH CLINIC# 63-38-98

The situation with Sharon Kowalski at Park Point Manor was reviewed by this examiner, with two other doctors involved with the case, Doctor Moller and Doctor George Cowan. I also have discussed the situation with one of the head nurses at Park Point Manor, and have asked for a psychological assessment by Jerry Henkel-Johnson, the psychologist at Park Point. Everybody did agree that Sharon become more depressed recently, and because of this, I did look towards the two psychologists and Doctor Cowan, the psychiatrist, for supporting recommendations as to the best way to handle this problem.

In discussing the situation with Doctor Cowan, he very specifically stated that he felt that the patient was suffering from a reactive depression, largely based upon her reactions to statements that she heard from Karen Thompson. He felt specifically that this was the case, and not that Sharon was depressed because of withdrawal from companionship or from withdrawal from the St. Cloud environment. Doctor Cowan reported that he had indeed documented negative response on the part of the patient to statements made specifically by Karen Thompson. We are both in agreement that the current cognitive status of Sharon does not allow for any sophisticated interpretation on her part of statements made to her by others. Thus, the suggestion by Karen Thompson that she was not in the

proper environment of an institution could potentially have very negative effects on her. This opinion was also echoed by her attending physician, Doctor Moller, who has been seeing her on a monthly basis at Park Point.

Thus, based on my own assessment and the recommendations of these two physicians, the staff at Park Point, I do concur with their recommendations that accessibility to Sharon on the part of Karen Thompson should be eliminated. It was Doctor Cowan's recommendation that there be no interaction between these two individuals at this time. Obviously, follow-up in this situation would be needed, both by the psychologists involved, the staff at Park Point, and Doctor Cowan.

Sincerely,

/s/ Steven K. Goff, M.D.
Physical Medicine and Rehabilitation

SKG/BJH

THE DULUTH CLINIC, LTD.

400 East Third Street
Duluth, MN 55805

J. Fena, Att.-at-Law
311 E. Howard Street
P.O. Box 667
Hibbing, Minn. 55746

July 25, 1985

Dear Mr. Fena: Re/ Sharon Kowalski

As of to-day, July 25th, 1985, the opinions, conclusions and recommendations expressed in my letter of May 7th, 1985 and at the deposition taken July 3rd, 1985 remain unchanged.

Yours Truly,

J. C. Moller, M.D.

ADAMS CLINIC, P.A.

August 20, 1985

Jack Fena, Attorney
311 East Howard Street
Hibbing, MN 55746

2229 3RD AVENUE EAST
HIBBING, MN 55746
218/262-3425

400 NW 1ST STREET
CHISHOLM, MN 55719
218/254-3391

Dear Mr. Fena:

As per your request for a medical report on Sharon Kowalski concerning her current medical and psychological condition and her ability to deal with visitations from Karen Thompson, this report is based on an extensive review of her medical and psychological evaluations since her accident on November 13, 1983. This would include reports from Dr. Goff at Polinski Institute in Duluth and her attending physician, Dr. Moller, from the Duluth Clinic and psychiatric reports from Dr. Cowan in Duluth. It is also based on previous court testimony and depositions from various parties involved in this case. It is also based on my direct observation of the patient and observations of personnel at Leisure Hills Nursing Home.

Sharon was originally injured in an automobile accident on November 13, 1983, suffering severe head trauma. This has left her with a severe upper and lower extremity paresis with severe cognitive dysfunction and minimal communication skills. Sharon was recently transferred from Park Point Manor in Duluth to Leisure Hills Nursing Home in Hibbing, and I am currently her attending physician. I visit her on a monthly basis. Based on her

previous records and my observations, I do not feel that Sharon has improved significantly over the past six months. I feel that her mental functioning and cognitive status have stabilized and probably will not significantly improve in the future. I would concur with previous reports that Sharon continues to cognitively function at below a 6 or 7 years of age level, and that she should be classified as a highly vulnerable adult who could easily be subjected to various forms of abuse including manipulation and sexual abuse. Sharon has also suffered recurrent bouts of reactive depression which, according to many medical observers, have been closely associated with her interaction with Karen Thompson. Ms. Thompson has apparently been visiting Sharon on a regular basis for approximately the past week at the Leisure Hills Nursing Home. According to affidavits and statements from individuals who have observed this interaction at Park Point Manor, it has come to my attention that Karen Thompson has been involved in bathing Sharon Kowalski behind a closed door for a prolonged period of time. It has also come to my attention that Ms. Thompson has alleged a sexual relationship with Sharon Kowalski that existed prior to the accident.

Based on this knowledge and my best medical judgement concerning Sharon and her welfare, I feel that visits by Karen Thompson at this time would expose Sharon Kowalski to a high risk of sexual abuse and I also believe that such visits would again expose Sharon to recurrent bouts of reactive depression that have greatly impeded her recovery in the past. I also have been made aware that Karen Thompson has, at times in the past, been involved in directly administering physical thearpy to Sharon Kowalski.

Because of Sharon's physical problems, I feel that such therapy administered by a non-professional could be extremely dangerous to her health and long term recovery. Thus as Sharon's physician, I have directed the Leisure Hill's nursing home staff to allow Karen Thompson to visit Sharon Kowalski under any circumstances and that Sharon is to receive physical therapy only from a qualified therapist. These orders are based on what I feel is in Sharon's best interests from a medical and psychological standpoint.

Sincerely,

/s/ William L. Wilson, M.D.
Adams Clinic, P.A.
Higging, MN 55746

WLW/st

STATE OF MINNESOTA
IN COURT OF APPEALS

In Re: Guardianship of:
Sharon Kowalski
Ward.

AFFIDAVIT OF GEORGE M. COWAN, M.D.

Trial Court Case No. 4497

Appellate Court Case No.
C1-85-1502

STATE OF MINNESOTA)
) SS
COUNTY OF ST. LOUIS)

GEORGE M. COWAN, M.D., Having been first duly sworn upon oath, deposes and says:

1. That my name is George M. Cowan, M.D., and I am a medical doctor whose specialty is psychiatry and I practice in the City of Duluth, Minnesota, and I have been engaged in such practice and specialty for over 35 years and am senior member and founder of Cowan Psychiatric Associates, 330 Medical Arts Building, Duluth, Minnesota;

2. In the latter part of September, 1984, I was posted at Miller/Dwan Hospital for a psychiatric examination of Sharon Kowalski, and I did on or about October 4, 1984, see Sharon Kowalski at Miller/Dwan Hospital. I sent Mr. Jack Fena, attorney for Donald Kowalski, the guardian herein, a medical report dated October 14, 1984, which is attached to this affidavit as Exhibit A;

3. That on or about May 3, 1985 I testified at a trial in Elk River, Minnesota, relative to controversy over Sharon Kawalski's guardianship and visits by Karen Thompson;

4. At that hearing I testified that I had examined Sharon Kowalski and that I had interviewed various nursing home personnel at the Park Point Nursing Home in Duluth. I also reviewed all of her charts and history and nursing home notes and based upon that, and my examination, I testified that Sharon Kowalski was depressed and that in my opinion the depression was caused and exacerbated by the conduct of Karen Thompson during her visits to Sharon Kowalski. It is apparent from the records that Karen Thompson was giving very negative messages to Sharon Kowalski about her parents and about the quality of care that she was receiving at Park Point Manor Nursing Home in Duluth, and her medical care. It was my opinion that Sharon was receiving adequate medical care and nursing home care;

5. At this hearing I also testified that if I had been Sharon's attending physician rather than her psychiatric consultant, I would issue an order banning any contact between Karen Thompson and Sharon Kowalski;

6. I also testified that I have treated gay and lesbian persons and that many gay and lesbian persons do not wish to have their sexual preference or orientation disclosed to third parties, and that many of them keep this a secret. I also testified that gay and lesbian persons most fear disclosure of their sexual preference and orientation to their parents. It is my opinion that the right of disclosure of one's sexual orientation and sexual preference is uniquely an individual's own prerogative;

7. It is my opinion, based upon my examinations and perusal of the medical and nursing home records, that Sharon Kowalski remains profoundly brain damaged and

I agree with the rehabilitation conference report that is hereto attached as Exhibit B;

8. One of the outstanding things that I agree with in this evaluation is on page 3, fourth line from the bottom, which reads in part " . . . her cognitive functioning ability would be below a 6 or 7 year age level . . . . " The entire initial evaluation and history dated October 9, 1984, which took place over a number of days after she was admitted to Nat Polinsky Rehabilitation Unit at Miller/Dwan Hospital and Medical Center on September 14, 1984, was seen and read by myself and used by me in forming my opinions relative to Sharon Kowalski;

9. Sharon Kowalski remains profoundly mentally and physically disabled and this condition is permanent. My opinion remains that total control of Sharon's life should remain in the hands of her parents. I have found through the years that parental love is unconditional and lasting, whereas other associations, many times, disintegrate when there is a change in the status of one of the parties. This would be true in both heterosexual and homosexual relationships, in my opinion;

10. From what I have been able to observe and from consulting with all of her health care personnel at the hospital and nursing home, Sharon Kowalski's parents are doing a commendable and adequate job in administering and looking over their daughter, Sharon Kowalski;

11. It is my further opinion that the notorious publicity given to this matter by the press conferences, television, and news releases of Karen Thompson, and the disclosure of these press releases and news releases by Karen Thompson to Sharon Kowalski, have caused the conflict to

be laid upon Sharon Kowalski and have caused her to be insecure and fearful, therefore throwing her into depression;

12. Therefore, based upon the history, my own examinations, my perusal and study of the hospital and nursing home records, and my interviews of medical and nursing home personnel, it remains my opinion that any contact by Karen Thompson with Sharon Kowalski should be eliminated; it is my further opinion that the continued conflict in this matter creates a very dangerous situation for Sharon Kowalski;

13. In preparation for the making of this affidavit I was given a copy of an affidavit of Janlori Goldman dated August 5, 1985, attached hereto as Exhibit C, and a copy of an affidavit of Amy B. Bromberg dated August 6, 1985, attached hereto as Exhibit D. In both of these affidavits questions relative to representation by attorneys from the Minnesota Civil Liberties Union were asked of Sharon Kowalski and references were made to courts and court procedures;

14. It is my opinion based upon the history, the rehabilitation conference report dated October 9, 1984, conversations with her medical and nursing home personnel, perusal of medical and nursing home records, conferences with her attending physicians, and my own examination of Sharon Kowalski, that she would be unable to understand the questions and use the complex reasoning that would be required to give intelligent answers;

15. The whole, entire history shows that Sharon's brain damage causes her to be totally confused in answering questions. It is my opinion and belief that Sharon

does not have sufficient understanding to make reasoned, intelligent answers to the questions as shown in these affidavits;

16. It is my further opinion that the types of questioning and indication of conflict are very harmful to Sharon Kowalski as I had testified at the trial that similar questions and creating of conflict were harmful to Sharon Kowalski. These would be no different;

FURTHER AFFIANT SAITH NOT Except this affidavit is made for the purpose of indicating to the Court my reasons for my opinion of eliminating contact by Karen Thompson with Sharon Kowalski.

/s/ George M. Cowan, M.D.

Subscribed and sworn to before
me this 27 day of August, 1985.

/s/ Elizabeth Petrovic
Notary Public
(SEAL)